Ten Common Pitfalls in the Practice of IBD in Egypt

Sherif S Shabana, MD MRCP (UK)

Assistant Professor of Internal Medicine and Gastroenterology

Ainshams University

E-mail: drsherif_shabana@med.asu.edu.eg

There's no doubt that IBD is one of the fields in Egypt where malpractice is greatly encountered. I'm willing to start a series of "Common Pitfalls in the Practice of IBD in Egypt", aiming to highlight a few mistakes we see in our practice. I think that this in turn will have a great impact on the quality of care we provide to our patients. Please note, that these observations are purely my personal opinion based on what I've seen in my practice. It's not meant to be a guide for anyone, but rather my opinion on what I see as 'pitfalls ' in such a confusing field. Off course, open discussion and criticism is highly appreciated. I will start by posting a single pitfall each day for ten days!

- **Pitfall No. 1: Bad Communication!**

Yes, bad communication! This is by far the biggest pitfall in our practice when it comes to IBD patients. I see it as the main reason for problems like patients' poor compliance to therapy. This is especially true for those of us who work in busy clinics and don't have enough time for interviewing the patient and addressing his/her concerns. The IBD patient needs to understand that his is disease is chronic with no radical cure in most cases. He needs to know what's meant by an immune disease and that it's not just a temporary medical condition. Patients are usually unaware that they will probably need the treatment life long or at least for long periods of time. They are also unaware of the potential side effects of their medicines and how this translates into a benefit-risk relationship. Pregnant ladies are usually confused how will they manage their disease during pregnancy and

thereafter. I see this specially problematic for those coming from rural communities as well as those from a poor socio-economic background. Infact, sometimes I feel that these patients are embarrassed to ask questions!. Most of the time we give the impression that we are too busy to address their concerns (our body language says so!).The end result is bad quality care. In my opinion, the IBD patient needs at least 30 minutes during the initial interview. This seems reasonable to 'digest' most of the data needed to be relayed to the patient. Finally, remember that bad communication equals bad medicine!

- **Pitfall No. 2: Not Vaccinating Your IBD Patient.**

The uptake of required vaccines by IBD patients in western populations is reported to be around 40 to 50 percent. I can assume (although no statistics available) that this approaches almost zero percent in the Egyptian IBD population. This is almost exclusively due to the physician unawareness (or probably excess fear) of the importance of vaccination in such a highly vulnerable group of patients. The vast majority of IBD patients will require some form of immunosuppressive therapy at some point in their life. This puts them liable to a plethora of infections; some of which might be fatal. Generally speaking, all inactivated vaccines maybe given safely during immunosuppressive therapy. On the other hand, live attenuated vaccines are contraindicated within three months before, during and up to 6 weeks after immunosuppressive therapy. Therefore, it is better to administer these vaccines well before (more than 3 months) planned immunosuppression (if possible). All vaccines should be kept up to date according to our national schedule guidelines. I think special emphasis should be given to certain vaccines including the influenza vaccine, pneumococcal vaccine (both PCV-13 and PPSV-23), meningococcal vaccine and Hepatitis B vaccine. All those above 50 years should receive the Herpes zoster vaccine. At the end, it is this 'fine tuning ' that differs one physician from the other. So please, keep the vaccine status of your IBD patient up to date.

Here is a nice link for further reading: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5114511/#!po=35.8696

- **Pitfall No. 3: Not liaising with the Clinical Nutritionist**

This is a field where we are all defective. In the era of modern medicine, the evaluation and management of the patient's nutritional status goes beyond giving simple advice on what to eat and what to avoid. Patients with IBD are liable to different forms of malnutrition due to a variety of factors. We can frequently miss symptoms or signs of 'micronutrient' deficiency for example during our routine evaluation of these patients. It is therefore crucial to refer all our IBD patients (at least initially) to a clinical nutritionist for detailed sophisticated assessment. It goes without saying, that maintaining the nutritional status of patients will impact their overall quality of life and probably their will to fight their disease. Don't forget to have an annual assay of serum levels of albumin, vitamin D, calcium, magnesium, phosphorus and zinc. Vitamin B12 levels need to be measured at least annually in those with ileal Crohn's disease. Screen your patients for osteopenia/osteoporosis and give calcium supplements (1000- 1500 mg daily) together with vitamin D (600 units daily) to maintain bone health. Again, send your patient to the clinical nutritionist. Remember that, IBD is not a one man show.

- **Pitfall No. 4: Not Recognizing the Impact of the Disease on the Psycho-social state of the Patient.**

As physicians, we usually concentrate on the pharmacotherapy of the disease itself. Frequently, we act as if we are treating a disease and not a patient. We need to deal with the patient as a human being. Maybe our limited time in clinic poses an obstacle against properly evaluating the patient's emotional and psychological state. I strongly believe that IBD is a "psychologically debilitating" illness. We need to screen patients for hidden depression. In Egypt, the problem of IBD is even complicated further by the costs of drugs that need to be taken long-term. This puts much strain on our patients. Furthermore, the social hardships that most Egyptians experience adds to the psychological burden of this disease. We need to spend a few minutes showing empathy to our patients and establishing good patient rapport. This in turn will reflect on the patient's

compliance not only with his medications, but also with his fight against the disease. Active treatment of depression is mandatory in those suffering from it. If you are in doubt, refer your patient to your fellow psychiatrist.

- **Pitfall No. 5: Not Counselling Patients on the Risks of NSAIDs**.

The vast majority of Egyptian patients consume analgesics for both justifiable and non-justifiable reasons. Patients with IBD can experience pain from arthritis, spondylitis, cholelithiasis, urolithiasis and many other causes. This explains analgesic abuse in this patient population. Although the evidence is not that robust, but most reports in literature have agreed that non-steroidal anti-inflammatory drugs are associated with relapse of IBD. Some studies claim that NSAIDs can even induce 'new onset' IBD. This may apply more to non-selective NSAIDs, as the data regarding COX-II inhibitors yielded mixed results. Unfortunately, I didn't find a meta-analysis discussing this particular subject. However, I would prefer to lean on the safe side and explain to the patient that a few tablets of Diclofenac can result in a catastrophe.

- **Pitfall No. 6: Not Recognizing CMV and Clostridium Difficile as Potential Causes of a Flare.**

This is certainly an overlooked issue. Both CMV and C.difficile are more prevalent in the IBD population compared to normal individuals in the community. The presence of either of these infections is associated with frequent relapses, hospitalization and high colectomy rates in patients with IBD. Besides this, it is vital to exclude these diagnoses in cases of relapse/flare as their presence dictates a dramatic change in management (decreasing or stopping immunosuppression rather than escalating it). Although both infections should be excluded at each relapse, this approach is probably neither practical nor cost- effective in a country like Egypt. This is obvious because of several logistic issues including the lack of widespread laboratory testing for these infections, cost of testing and delayed reporting even when the tests are available. However, I think that an alternative and probably cost- effective strategy is to reserve testing for those patients who relapse despite being compliant and receiving

optimum doses of their medications or patients who demonstrate a poor response to therapy. So please, put CMV and C. Diff in mind

- **Pitfall No. 7: Not Prescribing LMWH for Patients Admitted With Acute Severe Ulcerative Colitis.**

It might seem a bit weird to prescribe heparin for a bleeding patient. But, yes, the guidelines have proved this to be evidence based. Patients with active IBD (especially those with acute severe disease) are frequently dehydrated, and usually have thrombocytosis. Besides other factors, this means that such patients are "thrombophilic". The ECCO has said it clearly in their latest 2017 consensus: ALL patients with acute severe colitis should be offered heparin for VTE prophylaxis. Don't forget to add 40 milligrams of Clexane subq the next time a case of acute severe ulcerative colitis is admitted. This might save your patient from a fatal pulmonary embolism.

- **Pitfall No. 8: Keeping Patients on Maintenance Steroid Therapy.**

I have seen this a dozen of times! Unfortunately, all of us have come across those prescriptions where patients were put on 5 or 10 milligrams of Prednisone for long periods of time. This is considered as bad practice of medicine and is not endorsed in any society guidelines. The term "steroid-dependence" was not proposed aiming to put patients on long term steroid therapy, but rather to seek alternative treatment. This is usually the suitable time point to introduce an immunomodulator and/or a biologic agent. Surprisingly, many physicians believe that low dose steroids are more safe than steroid sparing agents or biologics. This is not true! The long term deleterious side effects of steroids are well known, not to mention the lack of efficacy in controlling the disease properly. Please consider azathioprine or an anti-TNF agent if you have a patient with steroid dependent disease.

- **Pitfall No. 9: Failure To Optimize Therapy Before Moving On To the Next Step.**

A classic situation here is that concerning azathioprine. Many physicians don't prescribe azathioprine in a weight based manner. The result is a suboptimal dose of the drug. I believe that this is an "all or none " drug; either you push the dose to the desired therapeutic target or you don't get any benefit apart from side effects. There's no point in giving a 80 Kg patient one hundred milligrams of azathioprine. Another scenario is the use of small doses of Mesalamine (Pentasa) during induction of remission. It's also important to remember that combination therapy (both oral and topical 5-ASA) is more effective than either alone. For example, if a patient doesn't show satisfactory response to oral Pentasa, consider adding a topical preparation and vice versa. Always push your drugs to their maximum doses (therapeutic targets) before escalating therapy. The message is that it's a fight with relatively limited weapons in hand. So try to exhaust your options before moving to another one.

- **Pitfall No. 10: Using Steroids As First Line Therapy in Inducing Remission in Mild- Moderate Ulcerative Colitis.**

Although I don't consider this as a major pitfall in practice, but it carries a technical 'trick'. About 5% or less of patients may experience an 'acute intolerance syndrome ' when given 5-ASA compounds. This usually occurs in the form of a 'paradoxical' worsening of their colitis symptoms (bloody diarrhea, abdominal cramping, fever). This presents a clinical dilemma as it's often very difficult to differentiate it from a 'true' activity of the disease. When you give steroids initially to induce remission (together with Pentasa), this might mask this quite rare event. After withdrawal of steroids, you will not be able to tell if the patient is steroid dependent or just rarely had an exacerbation of his colitis (now unmasked) if he still had continued symptoms. Therefore, most of the society guidelines (including the ECCO) advise the use of 5-ASA compounds as first line therapies to

induce remission in patients with mild-moderate ulcerative colitis, reserving steroids as second line in cases of failure or intolerance to 5-ASA.